STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) MS #22273 at the facility from 08/16/23 to 08/17/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F600. Based on the facility's implementation of corrective actions taken on 08/01/23, prior to the SA entrance on 08/16/23, this was determined to be Past Non-Compliance. The facility was determined to be in compliance as of 08/03/23. The facility had a census of 105 at the time of the survey and held a license for 119 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to ensure that one (1) of three (3) residents	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/28/2023

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reviewed were protected from physical abuse. Resident #1. Based on the facility's implementation of corrective actions taken on 08/01/23, this was determined to be Past Non-Compliance.

Findings include:

Review of the facility's policy titled "Abuse, Neglect, Misappropriation, Exploitation Policy" dated January 2019, revealed, "Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations ...in accordance with Federal and State Laws...Definitions: ... Physical Abuse: Includes, but not limited to, hitting, slapping, punching, biting, and kicking ....."

Record review revealed an investigation dated 08/01/23 of an alleged physical abuse conducted by the facility involving Certified Nursing Assistant (CNA) #1 and Resident #1. At approximately 2:45 PM on 08/01/23, CNA #1 was assisting CNA #2 and CNA #3 with patient care on a combative resident (Resident #1) in resident's room. CNA #2 witnessed CNA #1 swat back at the resident and slapped the back of his (Resident #1) hand. CNA #3 reported that she heard a noise that sounded like a slap; but did not visually see the incident. CNA #1 reported that she was assisting CNA #2 and CNA #3 care for Resident #1 and that she (CNA #1) swatted resident's hand back while he (Resident #1) was being combative. CNA #2 and CNA #3 did not leave Resident #1's room until CNA #1 left the room. The incident was then immediately reported to the Administrator and Director of Nursing (DON). Resident #1 was assessed and found to have no injuries and no

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emotional distress. CNA #1 was immediately pulled off the floor, interviewed, and suspended pending investigation. The facility immediately began an investigation, reported the incident to the State Department of Health and to the Attorney General's Office. Resident #1's wife and Nurse Practitioner were notified and an immediate in-service on abuse and neglect was initiated with all staff. Resident's Care Plan was updated. An immediate Quality Assurance (QA) Meeting was held, and interviews were started with residents and staff.

On 08/16/23 at 9:45 AM, an interview with the Administrator (ADM), revealed that she had reported an allegation of abuse which happened between a CNA and Resident #1 on 08/01/23. She revealed that there were three staff members in the resident's room assisting him back to bed and changing his brief when it happened. She revealed that CNA #2 and CNA #3 came to her immediately and reported what happened after they made sure the resident was safe. ADM revealed that it was reported to her that Resident #1 was confused and combative when CNA #1 slapped him on the back of his hand. ADM revealed that when the incident was reported, Director of Nursing (DON) took CNA #1 immediately off the floor and suspended her pending investigation. ADM also revealed that she reported this immediately to State Department of Health and to the Attorney General's Office and completed a thorough investigation. ADM revealed that other residents were interviewed and there were no other allegations of verbal or physical abuse identified.

On 08/16/23 at 9:50 AM, an interview with DON, revealed that the incident between the CNA #1

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and Resident #1 happened around 2:45 PM on 08/01/23, in Resident #1's room. She revealed that there were two CNAs who witnessed this occurrence and DON stated, "One visualized it and the other heard it." DON revealed that CNA #2 and CNA #3 came immediately into the Administrator's office where she (DON), also was present. DON revealed that they reported that CNA #1, CNA #2, and CNA #3 were assisting Resident #1 into the bed and changing his brief, when he became combative. DON revealed that it was reported to them that CNA #1 slapped Resident #1 on the back of the hand. She also revealed that CNA #1 did not enter another resident's room after this occurred. DON revealed that she went immediately and pulled CNA #1 off the floor, and she was suspended pending investigation. DON revealed that this was considered abuse and was immediately reported to State Department of Health and to Attorney General's Office. DON revealed that they assessed Resident #1 and there was no redness noted to his hand and he was in no emotional distress. She also revealed that ADM interviewed other residents and there were no other allegations of abuse reported. DON confirmed that they in-service and train all staff on abuse and neglect and that this was an example of physical abuse.

On 08/16/23 at 10:20 AM, an observation and interview with Resident #1 revealed him sitting up in his wheelchair behind nursing desk with staff members present and he had an activity board in front of him with different gadgets he was fidgeting with. Resident #1 was alert, confused, able to answer only simple yes or no questions and was talking using random speech.

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On 08/16/23 at 1:00 PM, a phone interview with CNA #1, revealed that on 08/01/23, she went into Resident #1's room to help CNA #2 and CNA #3 get Resident #1 back to bed and get him changed. She revealed that resident was combative and pushing them back. CNA #1 revealed that she had let his bed down because she was afraid that he was going to fall the way he was fighting. CNA #1 revealed that Resident #1 grabbed her shirt and had a tight grip on it and wouldn't let go. CNA #1 stated, "I aggressively took his hand and snatched my shirt out of his grip." CNA #1 revealed that she never physically touched his hands, just took her shirt out of his grasp. CNA #1 revealed that CNA #2 and CNA #3 reported this to the Administrator and CNA #1 stated, "It was told to me that their story checked out." CNA #1 confirmed that she understood that she could lose her certification if the allegation of abuse was investigated, and she was found to be guilty. She stated, "I value my license." CNA #1 confirmed that she had been trained and in-serviced on abuse and neglect.

On 08/16/23 at 2:20 PM, an interview with CNA #2, revealed that she had witnessed CNA #1 slap Resident #1's hand. CNA #2 revealed that Resident #1 was not in his right mind, he was confused, often combative, physically, and verbally. CNA #2 revealed that she and CNA #3 entered Resident #1's room to help get him back in the bed and changed when CNA #1 came in to help. She revealed that this happened around 3:00 PM on 08/01/23. CNA #2 revealed that CNA #1 was on one side of the bed holding his hands for comfort while she (CNA #2) was cleaning him up. CNA #2 revealed that Resident #1 snatched his hands away from CNA #1 and that's when she (CNA #1) grabbed Resident #1's

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wrist with one hand, turned it over and slapped the top of his hand like he was a child misbehaving. CNA #2 stated, "I physically saw her slap his hand." CNA #2 revealed that CNA #3 was still in the room and heard the loud slap to the hand. CNA #2 revealed that she and CNA #3 went immediately to the Administrator's Office and reported this to the ADM and DON. CNA #2 stated, "She (CNA #1) hit someone, and this is physical abuse." CNA #2 revealed that the DON went down the hall and removed CNA #1 from the floor, and CNA #1 left that same day and hasn't been back. CNA #2 revealed that they had an in-service on Abuse after this incident and that all staff members were required to attend.

On 08/16/23 at 2:45 PM, an interview with CNA #3 revealed that Resident #1 had bad behaviors and that on 08/01/23 around 3:00 PM, she (CNA #3), CNA #2, and CNA #1 went into Resident #1's room, assisted him to bed and changed his brief. CNA #3 revealed that Resident #1 was combative, hitting and knocking and then she (CNA #3) heard a "hard slap". CNA #3 revealed that she didn't see it happen but heard it. CNA #3 stated, "I don't care who they are, if I see anyone hit a resident, I'm turning them in." CNA #3 revealed that she and CNA #2 made sure Resident #1 was safe and went immediately to Administrator's office and reported this abuse. CNA #3 revealed that the DON went and pulled CNA #1 off the floor and CNA #1 was later terminated. CNA #3 said, "I look at these folks as my grandparents, and I don't go for abuse."

Record review of the working Schedule for CNA #1, CNA #2, and CNA #3 documented that they were scheduled to work on the 2:00 PM - 10:00 PM shift on 08/01/23.

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Record review of time "Punch Data" for CNA #1 revealed that she clocked in at 1:52 PM on 08/01/23, and she clocked out at 2:51 PM on 08/01/23.

Record review of "Punch Data" for CNA #2 and CNA #3 revealed that they were clocked in on 08/01/23 and worked the 2:00PM to 10:00PM shift.

Record review revealed that CNA #1 was terminated on 08/01/23 for "Substantiated Abuse" of a demented resident.

Record review of "Progressive Discipline Form" on CNA #1 with "Date Administered: 08/03/23" documented Termination date effective 08/01/23 due to findings of investigation.

Record review of Resident #1's Admission Record revealed that the resident was admitted on 07/14/2023 with the following diagnoses to include: Idiopathic Normal Pressure Hydrocephalus, Unspecified Dementia, mild, with other Behavioral Disturbance, Generalized Anxiety Disorder, Mild Cognitive Impairment, Restlessness and Agitation, Repeated Falls, Weakness, and Other Reduced Mobility.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/21/2023 under Section C documented Brief Interview for Mental Status (BIMS) Score of 99 which indicated resident was unable to complete the interview due to significant cognitive deficits.

The State Agency (SA) validated through

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interview with the Administrator and record review that this incident of abuse was immediately investigated by the facility Administrator on 08/01/23.

The SA validated through interview with the Administrator and record review that a Quality Assurance meeting was held on 08/03/23 concerning the incident of abuse that occurred on 08/01/23.

The SA validated through interviews and record review of the sign in sheets that in services were conducted with all staff on Abuse and Neglect on 08/03/23.

The SA validated through interview that the Nurse Manager will interview 12 different residents a day for five (5) days, then 12 residents a month for three (3) months beginning 08/03/23.

The SA determined the facility was in compliance on 08/03/23 when CNA #1 was formerly terminated and in-services and investigation was concluded.